Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN3003	A. BUILDING _____ B. WING _____	11/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUGHLIN HEALTH CARE CENTER	801 E MCKEE ST GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments An annual Licensure survey and complaint investigation #28182 were completed on November 28-30, 2011, at Laughlin Health Care Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	**Laughlin Healthcare Center acknowledges during the Annual Licensure Survey and Complaint Investigation # 28182, completed on November 28-30, 2011, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.**	

Division of Health Care Facilities

B. B. A.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: NURSING HOME ADMINISTRATOR

(X6) DATE: 12-09-11